Victorian Clinical Genetics Services
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Consumer Feedback Form

Tell us about your experience; compliments, suggestions or any concerns you have about our service.

About You

(I am a patient ☐ parent ☐ carer ☐ health professional ☐ or, I wish to remain anonymous ☐

First Name: _____ Surname: _____

Address: _____

_____ Postcode: _____

Preferred Contact [Phone or Email details]: _____

If you would like an interpreter, which language: _____

I would ☐ would not ☐ like to be contacted regarding this feedback.

About the Patient (leave blank if you are the patient)

First Name: _____ Surname: _____

Hospital UR (if known): _____ Date of Birth: _____

The Service - Test or Clinical Support (that you are providing feedback about)

Service: _____

Person: _____

Your Feedback (if space is inadequate, please attach a letter outlining your feedback)

Date: _____

Thank you! Victorian Clinical Genetics Services values your feedback, we will be in touch soon. Please hand your feedback to one of our staff, or **Fax:** 8341 6390, **Email:** vcgs@vcgs.org.au or mail your feedback to:

Clinical Quality Liaison Officer
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